Adopted	Rejected

COMMITTEE REPORT

YES: 10
NO: 0

MR. SPEAKER:

Your Committee on **Public Health**, to which was referred House Bill 1462, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill **be amended** as follows:

1 Page 1, between the enacting clause and line 1, begin a new
2 paragraph and insert:
3 "SECTION 1. IC 12-23-20-2, AS AMENDED BY P.L.32-2021,
4 SECTION 32, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
5 JULY 1, 2023]: Sec. 2. (a) This section does not apply to a health care
6 provider providing services in any of the following:
7 (1) An adult or juvenile correctional facility operated by the state
8 or a local unit.
9 (2) A hospital licensed under IC 16-21-2.
10 (3) A facility that is certified by the division.
11 (4) An opioid treatment program that has been certified or
12 licensed by the division under IC 12-23-18.
13 (5) A state institution.
14 (6) A health facility licensed under IC 16-28.

(7) The Indiana Veterans' Home.

(b) A physician who is providing office based opioid treatment or who is acting in a supervisory capacity to other health care providers that are providing office based opioid treatment must:

(1) have ~~both:~~

~~(A) a waiver from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and meet the qualifying standards required to treat opioid addicted patients in an office based setting; and~~

~~(B)~~ a valid federal Drug Enforcement Administration registration number and identification number; ~~that specifically authorizes treatment in an office based setting;~~ and

(2) abide by all:

(A) federal; and

(B) state;

laws and regulations concerning the prescribing of medications.

(c) A health care provider that prescribes for a patient in an office based opioid treatment setting shall do and document the following:

(1) Determine the patient's age.

(2) Perform an initial assessment and a physical examination as appropriate for the patient's condition and the health care provider's scope of practice and obtain a medical history of the patient before treatment begins.

(3) Obtain substance use history and any substance use disorder diagnosis of the patient.

(4) Perform a mental health assessment.

(5) Obtain informed consent for treatment and establish a treatment agreement with the patient that meets the requirements set forth in subsection (d).

(6) If determined appropriate, prescribe office based opioid treatment for the patient and require office visits of the patient in person throughout treatment.

(7) Evaluate the patient's progress and compliance with the treatment agreement and document the patient's progress with the treatment plan.

(8) Perform toxicology screening for the following in accordance with rules adopted under IC 25-22.5-2-7(a)(14) in order to assess medication adherence and to screen for other substances:

1 (A) Stimulants.
2 (B) Alcohol.
3 (C) Opioids, including:
4 (i) oxycodone;
5 (ii) methadone; and
6 (iii) buprenorphine.
7 (D) Tetrahydrocannabinol.
8 (E) Benzodiazepines.
9 (F) Cocaine.
10 (9) Review INSPECT (as defined in IC 25-26-24-7) concerning
11 controlled substance information for the patient before induction
12 and at least four (4) times per year during treatment.
13 (10) If the patient is a female and has child bearing potential:
14 (A) perform a pregnancy test at the onset of treatment;
15 (B) counsel the patient about the risks of treatment to a fetus,
16 including fetal opioid dependency and neonatal abstinence
17 syndrome; and
18 (C) provide for or refer the patient to prenatal care, if the
19 pregnancy test performed under clause (A) is positive.
20 (11) Prescribe an overdose intervention drug and education on
21 how to fill the prescription when buprenorphine is initiated on the
22 patient.
23 (12) Provide for an ongoing component of psychosocial
24 supportive therapy, with direction from the health care provider
25 on the amount of the therapy.
26 (d) The treatment agreement required in subsection (c)(5) must
27 include at least the following:
28 (1) The goals of the treatment.
29 (2) The patient's consent to drug monitoring testing.
30 (3) The prescriber's prescribing policies that include at least the
31 following:
32 (A) A requirement that the patient take the medication as
33 prescribed.
34 (B) A prohibition on sharing or selling the medication.
35 (C) A requirement that the patient inform the prescriber about
36 any:
37 (i) other controlled substances or other medication
38 prescribed or taken by the patient; and

1 (ii) alcohol consumed by the patient.
2 (4) The patient's consent to allow the prescriber to conduct
3 random pill counts for prescriptions.
4 (5) Reasons that the office based opioid treatment of the patient
5 may be changed or discontinued by the prescriber.
6 The provider shall maintain a copy of the informed consent for
7 treatment in the patient's medical record.
8 (e) During the examinations required by subsection (c)(6), the
9 prescriber shall do the following:
10 (1) Evaluate and document patient progress and compliance with
11 the patient's treatment plan.
12 (2) Document in the patient's medical record whether the patient
13 is meeting treatment goals.
14 (3) Discuss with the patient the benefits and risks, if relevant, of
15 ongoing buprenorphine treatment.
16 (f) If a toxicology screening described in subsection (c)(8) shows an
17 absence of a prescribed drug, the provider must discuss and implement
18 a plan with the patient to optimize medication adherence and schedule
19 an earlier follow up appointment with the patient. The provider shall
20 document the discussion in the patient's medical record.
21 (g) If a toxicology screening described in subsection (c)(8) shows
22 a presence of an illegal or nonprescribed drug, the provider shall assess
23 the risk of the patient to be successfully treated and document the
24 results in the patient's medical record.
25 (h) The provider may perform a subsequent confirmation toxicology
26 screening of the patient if the provider considers it medically necessary
27 or to clarify an inconsistent or unexpected toxicology screening
28 result.".
29 Page 1, delete lines 16 through 17.
30 Page 2, delete lines 1 through 21, begin a new line block indented
31 and insert:
32 "**(1) An incorporation of the screening, brief intervention, and**
33 **referral to treatment screening tool.**
34 **(2) An analysis of the emergency department's ability to and**
35 **a plan to:**
36 **(A) begin initiation of medication before discharge; and**
37 **(B) coordinate outpatient medication referrals upon**
38 **discharge.**

1 **(3) A procedure to initiate or connect substance use patients**
2 **to medication assisted treatment for addiction disorders,**
3 **including:**
4 **(A) treatment for opioid use disorder and alcohol use**
5 **disorder; and**
6 **(B) providing immediate access to:**
7 **(i) naloxone;**
8 **(ii) an opioid antagonist that can reverse opioid**
9 **overdoses; and**
10 **(iii) all federal Food and Drug Administration approved**
11 **medications for the treatment of opioid use disorder and**
12 **alcohol use disorder.**
13 **(4) A detailed protocol to connect patients with substance use**
14 **disorders to treatment, prevention, recovery, peer support**
15 **services, and harm reduction services upon discharge from**
16 **the emergency department.**
17 **(5) The emergency department's plan to implement a**
18 **continuing education and training program to emergency**
19 **department personnel on:**
20 **(A) substance use disorder; and**
21 **(B) best practices for emergency medical care delivery for**
22 **patients who are most at risk of dying after emergency**
23 **room discharge.**".
24 Page 2, line 25, after "(e)" insert "**This subsection applies after**
25 **December 31, 2023.**".
26 Page 2, line 28, delete "necessary." and insert "**necessary in both**
27 **an inpatient facility of a hospital and an emergency department.**".
28 Page 2, delete lines 29 through 37, begin a new paragraph and
29 insert:
30 "SECTION 2. IC 25-26-24-19, AS ADDED BY P.L.51-2019,
31 SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
32 JULY 1, 2023]: Sec. 19. (a) Information received by the INSPECT
33 program under section 17 of this chapter is confidential.
34 (b) The board shall carry out a program to protect the confidentiality
35 of the information described in subsection (a). The board may disclose
36 the information to another person only under subsection (c), (d), or (g).
37 (c) The board may disclose confidential information described in
38 subsection (a) to any person who is authorized to engage in receiving,

processing, or storing the information.

(d) Except as provided in subsections (e) and (f), the board may release confidential information described in subsection (a) to the following persons:

(1) A member of the board or another governing body that licenses practitioners and is engaged in an investigation, an adjudication, or a prosecution of a violation under any state or federal law that involves ephedrine, pseudoephedrine, or a controlled substance.

(2) An investigator for the consumer protection division of the office of the attorney general, a prosecuting attorney, the attorney general, a deputy attorney general, or an investigator from the office of the attorney general, who is engaged in:

(A) an investigation;

(B) an adjudication; or

(C) a prosecution;

of a violation under any state or federal law that involves ephedrine, pseudoephedrine, or a controlled substance.

(3) A law enforcement officer who is an employee of:

(A) a local, state, or federal law enforcement agency; or

(B) an entity that regulates ephedrine, pseudoephedrine, or controlled substances or enforces ephedrine, pseudoephedrine, or controlled substances rules or laws in another state;

that is certified to receive ephedrine, pseudoephedrine, or controlled substance prescription drug information from the INSPECT program.

(4) A practitioner or practitioner's agent certified to receive information from the INSPECT program.

(5) An ephedrine, pseudoephedrine, or controlled substance monitoring program in another state with which Indiana has established an interoperability agreement.

(6) The state toxicologist.

(7) A certified representative of the Medicaid retrospective and prospective drug utilization review program.

(8) A substance abuse assistance program for a licensed health care provider who:

(A) has prescriptive authority under this title; and

(B) is participating in the assistance program.

(9) An individual who holds a valid temporary medical permit issued under IC 25-22.5-5-4 or a noneducational commission for foreign medical graduates certified graduate permit issued under IC 25-22.5-5-4.6.

(10) A county coroner conducting a medical investigation of the cause of death.

(11) The management performance hub established by IC 4-3-26-8.

(12) The state epidemiologist under the state department of health.

(e) Information provided to a person under:

(1) subsection (d)(3) is limited to information:

(A) concerning an individual or proceeding involving the unlawful diversion or misuse of a schedule II, III, IV, or V controlled substance; and

(B) that will assist in an investigation or proceeding;

(2) subsection (d)(4) may be released only for the purpose of:

(A) providing medical or pharmaceutical treatment; or

(B) evaluating the need for providing medical or pharmaceutical treatment to a patient; and

(3) subsection (d)(11) must be released to the extent disclosure of the information is not prohibited by applicable federal law.

(f) Before the board releases confidential information under subsection (d), the applicant must be approved by the INSPECT program in a manner prescribed by the board.

(g) The board may release to:

(1) a member of the board or another governing body that licenses practitioners;

(2) an investigator for the consumer protection division of the office of the attorney general, a prosecuting attorney, the attorney general, a deputy attorney general, or an investigator from the office of the attorney general; or

(3) a law enforcement officer who is:

(A) authorized by the state police department to receive ephedrine, pseudoephedrine, or controlled substance prescription drug information; and

(B) approved by the board to receive the type of information released;

1 confidential information generated from computer records that
2 identifies practitioners who are prescribing or dispensing large
3 quantities of a controlled substance.
4 (h) The information described in subsection (g) may not be released
5 until it has been reviewed by:
6 (1) a member of the board who is licensed in the same profession
7 as the prescribing or dispensing practitioner identified by the data;
8 or
9 (2) the board's designee;
10 and until that member or the designee has certified that further
11 investigation is warranted. However, failure to comply with this
12 subsection does not invalidate the use of any evidence that is otherwise
13 admissible in a proceeding described in subsection (i).
14 (i) An investigator or a law enforcement officer receiving
15 confidential information under subsection (c), (d), or (g) may disclose
16 the information to a law enforcement officer or an attorney for the
17 office of the attorney general for use as evidence in the following:
18 (1) A proceeding under IC 16-42-20.
19 (2) A proceeding under any state or federal law.
20 (3) A criminal proceeding or a proceeding in juvenile court.
21 (j) The board may compile statistical reports from the information
22 described in subsection (a). The reports must not include information
23 that identifies any practitioner, ultimate user, or other person
24 administering ephedrine, pseudoephedrine, or a controlled substance.
25 Statistical reports compiled under this subsection are public records.
26 (k) Except as provided in subsection (q) **and (r),** and in addition to
27 any requirements provided in IC 25-22.5-13, the following practitioners
28 shall obtain information about a patient from the data base either
29 directly or through the patient's integrated health record before
30 prescribing an opioid or benzodiazepine to the patient:
31 (1) A practitioner who has had the information from the data base
32 integrated into the patient's electronic health records.
33 (2) A practitioner who provides services to the patient in:
34 (A) the emergency department of a hospital licensed under
35 IC 16-21; or
36 (B) a pain management clinic.
37 (3) Beginning January 1, 2020, a practitioner who provides
38 services to the patient in a hospital licensed under IC 16-21.

1 (4) Beginning January 1, 2021, all practitioners.
2 However, a practitioner is not required to obtain information about a
3 patient who is subject to a pain management contract from the data
4 base more than once every ninety (90) days.
5 (l) A practitioner who checks the INSPECT program either directly
6 through the data base or through the patient's integrated health record
7 for the available data on a patient is immune from civil liability for an
8 injury, death, or loss to a person solely due to a practitioner:
9 (1) seeking information from the INSPECT program; and
10 (2) in good faith using the information for the treatment of the
11 patient.
12 The civil immunity described in this subsection does not extend to a
13 practitioner if the practitioner receives information directly from the
14 INSPECT program or through the patient's integrated health record and
15 then negligently misuses this information. This subsection does not
16 apply to an act or omission that is a result of gross negligence or
17 intentional misconduct.
18 (m) The board may review the records of the INSPECT program. If
19 the board determines that a violation of the law may have occurred, the
20 board shall notify the appropriate law enforcement agency or the
21 relevant government body responsible for the licensure, regulation, or
22 discipline of practitioners authorized by law to prescribe controlled
23 substances.
24 (n) A practitioner who in good faith discloses information based on
25 a report from the INSPECT program either directly through the data
26 base or through the patient's integrated health record to a law
27 enforcement agency is immune from criminal or civil liability. A
28 practitioner that discloses information to a law enforcement agency
29 under this subsection is presumed to have acted in good faith.
30 (o) A practitioner's agent may act as a delegate and check INSPECT
31 program reports on behalf of the practitioner.
32 (p) A patient may access a report from the INSPECT program that
33 has been included in the patient's medical file by a practitioner.
34 (q) A practitioner is not required under subsection (k) to obtain
35 information about a patient from the data base or through the patient's
36 integrated health record before prescribing an opioid or benzodiazepine
37 if any of the following apply:
38 (1) The practitioner has obtained a waiver from the board because

1 the practitioner does not have access to the Internet at the
2 practitioner's place of business.
3 (2) The patient is:
4 (A) recovering; or
5 (B) in the process of completing a prescription that was
6 prescribed by another practitioner;
7 while still being treated as an inpatient or in observation status.
8 (3) The data base described in section 18 of this chapter is
9 suspended or is not operational if the practitioner documents in
10 writing or electronically the date and time in the patient's medical
11 record that the practitioner, dispenser, or delegate attempted to
12 use the data base.
13 **(r) A practitioner is not required under subsection (k) to obtain**
14 **information about a patient from the data base or through the**
15 **patient's integrated health record before prescribing an opioid or**
16 **benzodiazepine if the patient is enrolled in a hospice program (as**
17 **defined in IC 16-25-1.1-4).**".
18 Renumber all SECTIONS consecutively.
(Reference is to HB 1462 as introduced.)

and when so amended that said bill do pass.

Representative Barrett